

A level play

Dr Darrin Baines argues that LPCs should avoid getting involved in redesigning local pharmaceutical services



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Local pharmaceutical committees (LPCs) originally drew their authority from Section 44 of the 1977 NHS Act, which permits the Secretary of State to recognise committees that are representative of people providing pharmaceutical services in the locality of a health authority. With the publication of the NHS Reform & Health Care Bill, this is about to change.

Until now, LPCs have been based at health authority level within the NHS. If enacted, the Bill will change the level at which LPCs operate within the NHS in a way that reflects the abolition of health authorities in April 2002, and mirrors the growing trend of establishing primary care trusts (PCTs) to run the NHS locally.

Under Section 5(4) of the Bill, PCTs will be able to recognise an LPC formed for its area (or for the area of one or more other PCTs) if it is representative of people providing pharmaceutical services from premises in that area.

In other words, each PCT may agree to work with a particular LPC as long as it feels that the committee properly represents local pharmacy providers.

Under the Bill, PCTs will be mainly concerned with whether LPCs are representative, rather than with their size and structure. At one end of the spectrum, we could see large LPCs covering several PCTs but still able to represent all contractors in each area. At the other, we could see an LPC based on one PCT which

refuses to recognise it because it considers it unrepresentative. In future, LPCs will need to focus on whether they are actually representing their local members rather than on the size and structure of their committees.

In this article I will:

- examine the purpose of LPCs and argue that, in a changing NHS, they need to reaffirm the principles upon which they are built
- argue that the procedures LPCs follow are more important than their structure when it comes to representing local contractors
- suggest that LPCs should concentrate on developing fair procedures for representing their members.

To an observer, it appears that

ing field for all

LPCs are currently torn between evolving into mini-PCG/Ts, and retrenching their activities so that they are only concerned with professional disputes.

In the uncertain environment currently facing pharmacy, perhaps LPCs should avoid involvement in re-designing local pharmacy services and concentrate on making the local market for pharmacy services a fairer place.

Only by promoting a level playing field for local contractors can LPCs secure the type of representation I believe should be demanded by all PCTs.

Some contractors, of course, may feel this suggestion is "off beam" or far from their own vision of the future. I do not know what the final word should be on many of the issues raised here. I am simply trying to further the debate taking place locally on the future of LPCs within the NHS.

LPCs have been established to represent people providing pharmaceutical services in an area defined by a PCT boundary. This objective can be deconstructed into three main guiding principles:

- LPCs should be representative of all pharmacy contractors or "service providers" working in pharmacy (but not all providers of pharmaceutical services, such as dispensing doctors or nurses supplying drugs under patient group directions)
- LPCs owe an equal duty to all contractors they represent, regardless of their place of work, to support their interests as individuals and as a group
- LPCs should represent pharmacy contractors to the local PCT, and should be involved in building relationships with the local pharmaceutical advisers and PCT management.

With such guiding principles, LPCs must be impartial and fair. In an attempt to be representative, most LPCs have adopted a model constitution that dictates the number of pharmacy contractors, Company Chemist Association nominees, and employee representatives they can have on their committees.

Although it appears fair, it does not guarantee fair procedures are

followed or equal outcomes are secured, as anyone with experience of committee work will know. With a bit of collusion, some loud voices and a detailed knowledge of the rules, a minority can easily manipulate a committee. Having rules governing the membership of LPCs only goes part of the way to promoting fairness for local contractors.

So far, LPCs have had a relatively easy time. The rules of engagement for pharmacy contractors are set nationally: all contractors are paid in the same way, the control of entry regulations have largely protected local businesses, and there is limited opportunity for doing real damage to existing outlets.

As a result, major conflicts tend to be short-lived, while friction between independents and national chains creates minor tensions just below the surface.

In the new NHS, all this may change. The Office of Fair Trading (OFT) is currently investigating the legitimacy of contract limitation, weighing public interest against competition law. A new remuneration system for contractors may be introduced, and local contracts for pharmacy services will soon be launched under the Local Pharmaceutical Services (LPS) scheme.

In this new environment, the tensions in existing structures will become more evident. Some contractors will struggle to adapt and two tiers may develop – those in the know and those struggling on the outside. To deal with the problem of uneven knowledge, power, resources and contacts between local providers, LPCs may need to re-consider what they mean by "fairness".

New policies for promoting a "level playing field" amongst local contractors should be considered. If a programme of training, resource allocation and network introductions is offered to each contractor, and LPCs are set targets for securing everybody's involvement, equality of opportunity could be secured.

Once each contractor is equally equipped, it is up to individuals to respond to the new opportunities

open to them. By creating a level playing field, LPCs can still treat all contractors equally, but may be able to avoid the conflicts that will arise once local businesses pursue their own self-interest as NHS pharmacy suddenly changes.

In the coming months, LPCs will be stretched as new opportunities for pharmacists suggest that new procedures to ensure fairness should be put into place.

For instance, LPCs may have the opportunity to design local medicines management schemes, construct LPS pilots, decide local payment structures for work and influence the design of new incentive systems.

I would strongly suggest all LPCs should avoid any issues related to designing or running new pharmacy services for the following reasons:

- most new services will only involve a small proportion of local contractors, so LPCs risk their impartiality by promoting them
- health service issues – such as budget-setting or incentive design – involve specialist skills most LPCs may not have, even if their members are keen and want to be involved
- if LPCs are on the inside of the health service, they can't divorce themselves from the schemes they have championed if these fail. Involvement, therefore, automatically diminishes their ability to be truly representative.

In order to preserve their impartiality LPCs should re-trench and limit their involvement to issues solely related to proprietor representation. They should not try to re-design the system within which local pharmacies operate.

At present, national contracts, fixed dispensing fees and contact limitation mean that LPCs have relatively little to do compared to the tasks ahead. In the new environment facing pharmacists,

the problems facing local contractors may grow as they try to adapt to unfamiliar working arrangements.

LPCs will need to re-examine their core activities and main purpose. They should acknowledge their limitations and strengths, and consult with all local proprietors before they embark on ventures such as designing LPS pilots.

If they consult with all interested parties, they may find some contractors object to the innovative ventures promoted by their local LPCs, as they will affect their commercial interests. By introducing a consultation process, LPCs can legitimise their activities and discover the boundaries of their roles.

Indeed, consultation may indicate to some LPCs that they should focus on their traditional tasks, and should avoid evolving into specialist management bodies which lack the powers of their PCG/T counterparts.

LPCs may become more like local medical committees, which advise on many issues but let the important decisions be taken by their peers on the local PCG/Ts.

LPCs feel they should respond as the pharmacy and NHS environments evolve. However, sometimes the best way to respond to new challenges is to avoid them and stick to what you do best. If LPCs want to remain truly representative, their best strategy may be to remain locally based (Secretary of State permitting) and to pursue their core activity of resolving disputes rather than creating new opportunities for local pharmacies.

Although this message may not be welcomed in some quarters, I would suggest that LPCs should not decide their own futures but should outline different options and put their ideas out to consultation.

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